MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid Bulletin

Program and Policy Information

Volume 4, Issue 10 May 1998

Fee Schedules and Provider Manuals

EDS

Medicaid Charges for Fee Schedules and Provider Manuals

Medicaid fee schedules are available in hard copy form and on diskette. The current fee schedule contains 158 pages. The charge for a hard copy of the fee schedule is $92. The fee schedule on diskette costs $45.78.

One provider manual is provided for each provider number. If providers request additional manuals, they must submit their request in writing to the Division of Medicaid. The charge for an additional manual is $25 per manual plus postage. **(Please make all checks payable to the Division of Medicaid).**

All requests for information should be sent to :

Rose Compere
Information Officer
Division of Medicaid
239 North Lamar Street, Suite 801
Jackson, MS 39201-1399

Inside This Issue

Billing for Multiple Surgeries

Secondary surgeries are paid at 50% of the amount that is allowed when the surgery is primary.

As a result of our ongoing review of claims processing, it has been determined that multiple surgeries are frequently billed incorrectly.

In order for your claim(s) to pay correctly, it is imperative that the following instructions be followed. Claims billed with more than one surgical code for the same date of service must record the primary surgery code on line 1 of item 24D. Secondary surgery codes must be billed **with modifier 51** on lines 2 through 6 of item 24D. Bilateral surgeries must be billed with modifier 50.

Please be reminded that **secondary surgeries are paid at 50% of the amount that is allowed when the surgery is primary.**

Emergency Medical Screening Services

The Division of Medicaid and EDS, the fiscal agent, have received numerous inquiries relating to the billing policies for Emergency Medical Screening Services in the February, 1998 Medicaid Bulletin. To assist us in determining whether we need to address inquiries through a workshop or a provider bulletin, we are requesting that hospitals forward a complete list of questions **no later than May 15, 1998** to the Policy Division, Division of Medicaid, Robert E. Lee Bldg. - Suite 801, 239 North Lamar Street, Jackson, MS 39201-1399. The list of questions may also be faxed to Fax# 1-601-987-3916 or 987-3911.

Independent laboratories and radiologists will be required to report the Medicaid recipient's diagnosis on their submitted claim forms.

Independent Laboratories and Radiologists

Effective July 1, 1998, independent laboratories and radiologists will be required to report the Medicaid recipient's diagnosis on their submitted claim forms. The provider must enter the appropriate ICD-9-CM diagnosis code(s) in Item 21 of the HCFA-1500. A maximum of two (2) diagnoses may be reported (Items 21-1 and 21-2). Each detail line in Item 24 must reference the appropriate diagnosis code, **EITHER the first or the second**, but not both.

Precertification of Home Health Visits for Elderly and Disabled Waiver Recipients

All home health services provided to individuals enrolled in the Elderly and Disabled Waiver must be precertified by the appropriate waiver case managers. Treatment authorization numbers are currently being issued for home health services provided to recipients of the Elderly and Disabled Waiver Program. Case managers are phasing in their respective recipients' authorizations.

Home health agencies should always verify a recipients Medicaid eligibility **and** determine if the recipient is enrolled in the Elderly and Disabled Waiver or not. If the recipient **is not** enrolled in the Elderly and Disabled Waiver, precertification for home health services is through HSM. If the recipient **is** enrolled in the Elderly and Disabled Wavier, precertification for home health services is through their community based waiver case manager(s).

Changes in HealthMACS Policy Regarding PCP Admitting Privileges

Effective July 1, 1998, individual physician PCPs and HealthMACS physicians in a clinic/health center must have hospital admitting privileges or have a written agreement with a physician in a comparable specialty type who has hospital admitting privileges. Hospital admitting privileges are required in order to provide care and follow the HealthMACS patient's care throughout the hospital stay. This provision is required to eliminate hospital dumping. The PCP must submit to the Managed Care Division verification which confirms his/her hospital admitting privileges. PCPs who have an agreement with another physician to admit for him/her must submit to the Managed Care Division verification of that physician's hospital admitting privileges and a copy of written notification to the hospital explaining the agreement established for admitting HealthMACS patients for the PCP. HealthMACS patients should not be admitted as unreferred. It is not appropriate for HealthMACS patients to be admitted by another physician other than their PCP or the PCP's on-call professional unless arranged on a case-by-case basis or in emergency situations.

HealthMACS Policy Clarifications

Effective April 1, 1998, both emergent and urgent care situations presenting to the hospital emergency room require HealthMACS post authorization. HealthMACS post authorization requests require the PCP be notified within twenty-four (24) hours on weekdays and forty-eight (48) hours for weekend days and be provided information for the patient's medical record to determine the medical necessity of the services. The PCP will have a maximum of five (5) business days to review the medical information to determine if authorization is warranted. If the PCP determines that a HealthMACS authorization is needed, he/she will pass authorization specifying what he/she intends the authorization to be used for such as: for billing the medical assessment only or authorizing treatment and stabilization.

HealthMACS authorization must be obtained in order for Medicaid to pay hospitals for providing HealthMACS patients with a medical assessment which is required by law. If the medical assessment determines the HealthMACS patient's care is not urgent or emergent, the patient must be redirected to the PCP for primary health care needs and follow-up.

Any marketing including advertising and direct mail used by Medicaid providers to target HealthMACS recipients or Mississippi Medicaid/Managed Care recipients must be prior approved by the Division of Medicaid. If you would like to market your affiliation with Mississippi's Medicaid Managed Care Programs, you may call the Managed Care Division at 1-800-421-2408 for more information, or send your draft copy for review to 601-359-4185.

Managed Care Effective Dates

Changes in HealthMACS Policy Regarding Nurse Practitioner and Midwifery Participation

Effective July 1, 1998, certified nurse practitioners must have a protocol approved by the State Board of Nursing, be associated with a HealthMACS physician (no more than 60 miles away) who has approved the protocol, and be listed as the nurse practitioner's preceptor at the State Board of Nursing.

Claims Evaluation Software

Systematic changes are underway so that the chemotherapy administration is paid and the E&M service is denied as integral to the administration.

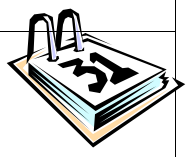
In our Special Issue Mississippi Medicaid Bulletin dated November 19, 1996, our claims evaluation software was introduced along with clarifications of and/or modifications to policy. This software is continually evaluated and updated in conjunction with our policies. We have determined that E&M codes are being reimbursed along with codes for chemotherapy administration. Systematic changes are underway so that the chemotherapy administration is paid and the E&M service is denied as integral to the administration.

Freestanding Rural Health Clinics

Reminder to Freestanding Rural Health Clinics - two (2) copies of Medicare cost reports and supporting documents must be submitted to Medicaid within the five-month period following cost report year end. Failure to submit timely will result in a penalty.

Nursing Facilities that Bill for Nurse Aide Training and Testing Expenses

All nurse aide training and testing expenses must be billed to Medicaid on a monthly basis.



All nurse aide training and testing expenses must be billed to Medicaid on a monthly basis. This will enable any problems noted in a facility's billing procedures to be corrected and ensure direct payment of all nurse aide training and testing costs.

The Division of Medicaid has two (2) cut-off periods for billing: December 31 and June 30. The cut-off dates are for Division of Medicaid budgeting purposes and year end accounting. Some facilities have been using these cut-off dates to submit expenses for three or more months at one time. During our last cut-off date of January 31, 1998, several facilities were denied direct reimbursement due to failure to comply with Division of Medicaid guidelines.

Facilities must bill nurse aide training and testing expenses monthly in order to receive reimbursement. Failure to comply with this requirement will result in denial of direct reimbursement of your expenses. All nurse aide training and testing expenses, including denied expenses, are nonallowable costs on the Medicaid cost report.

Should you have any questions about this requirement or the reimbursement process for nurse aide training and testing expenses, please contact Melinda Blum at 359-6081.

Anesthesia Services

System corrections are in-process to correct the payment problems for the codes listed below.

W9500	Insertion of arterial line (not for arterial puncture)
W9501	Insertion of CVP line
W9502	Insertion and placement of flow directed catheter (e. g., Swan-Ganz)

When an anesthesia provider inserts an arterial line, a CVP line, and/or a flow directed catheter (e.g. Swan-Ganz) in conjunction with anesthesia services for a surgical procedure, bill the appropriate code(s) from above and enter it in ITEM 24D on any of lines 2 through 4. **Effective immediately, all claims submitted with these codes must record type of service 7 in item 24C and only one (1) unit in item 25G**.

When an anesthesia provider inserts the above line(s) in conjunction with anesthesia services for a maternity related procedure, continue to bill type of service B and only one (1) unit.

Until the system corrections are completed, the payment problems will continue even when the instructions above are followed. As soon as the codes are processing correctly, an additional notice will be included on your RA banner page. Please continue to file the codes as instructed so that you will have a timely filing ICN.

Effective immediately, all claims submitted with these codes and not related to maternity related anesthesia must record type of service 7 in item 24C and only one (1) unit in item 25G.

Case Mix Update

The Case Mix Review Nurses began "live" audits of nursing facilities April 1, 1998.

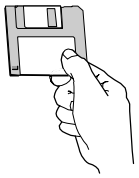
Facilities must continue to submit MDS data via diskette to the Division of Medicaid for payment. This policy has not changed. Assessments should be submitted on a bi-weekly basis.

When preparing files and diskettes for submission, please use the naming conventions as follows: Facility ID Code (99ZZ) Month (01-12) Day (01-31) Year (98). If facility 23KZ is submitting data on March 17, 1998, their submission file should be named "23KZ0317.98". The intent of this naming convention is to have unique file names with consistent extensions.

The quarterly closing date will be on the fifth (5th) day of the second (2nd) month following the end of the quarter. Assessments for a specific quarter which are received after the quarter has been closed will not be considered for the previous quarterly calculations, but will be reflected in subsequent quarterly and annual calculations.

Any questions related to the transmission of data for the National System should be directed to the State Department of Health, Licensure and Certification Division.

Facilities must continue to submit MDS data via diskette to the Division of Medicaid for payment.



Mississippi Medicaid Bulletin

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May 1998

S	M	T	W	T	F	S
EDS Correspondence Unit 1-800-884-3222 or 601-960-2800					1	2
3	Checkwrite 4	5	6	7 ESC Cut-Off 5 pm	8	9
Happy Mother's Day 10	Checkwrite 11	12	13	14 ESC Cut-Off 5 pm	Inquiries about Emergency Medical Screening Services need to be to the DOM 15	16
17	Checkwrite 18	19	20	21 ESC Cut-Off 5 pm	22	23
24 / 31	Checkwrite DOM & EDS Closed 25 MEMORIAL Day	26	27	28 ESC Cut-Off 5 pm	29	30

Checkwrites and Remittance Advises are dated every Monday. However, funds are not transferred until the following Thursday and Remittance Advices usually arrive the following Friday.